RAN+AMN

Arizona's Exclusive Provider Organization

PROVIDER NOMINATION FORM

This form is used to nominate a health care provider for participation in the RAN+AMN EPO network. You may wish to have the provider assist in the completion and submission of this form.

To nominate a physician:

1. Although not necessary, you may want to speak with your health care provider about joining the network.
2. You or your provider may submit the form below with as much information as available.
3. Once RAN+AMN EPO receives the completed documentation, the credentialing process will begin.
4. You or your provider may follow up with the network for a status of his application. You may contact the RAN+AMN EPO Provider Services Department at (480) 446-2462.
5. Note: RAN+AMN EPO can not guarantee that your health care provider will become a participating provider.

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Date:______________ Referring Member:____________________ Employer:_______________

Telephone:_______________ Fax:______________ E-mail Address:_______________________

THE FOLLOWING INFORMATION IS REQUESTED FOR PROCESSING

Provider Name:____

Primary Address:____

City:_____________________ County:_________________ State:_____________ ZIP:________

Telephone:_______________ Fax:___________________ Office Contact:__________________

E-mail Address: ____

Specialty:_____________________________ Hospital Affiliation:___________________________

Please mail or fax to:

RAN+AMN
1600 W Broadway RD STE 300
Tempe AZ 85282

Fax: (480) 214-4629

E-mail: ranamn@az-epo.com